Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-0145**

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

BOARD OF NURSING

APPLICATION FOR CERTIFICATION AS A NURSE-MIDWIFE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.)

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

The nurse-midwife license expires on February 28th of the even -numbered year. It may be renewed for a two year period at that time.

1. DO YOU HOLD CURRENT WISCONSIN LICENSURE AS A PROFESSIONAL NURSE?
YES ☐ NO ☐ WI License # _____ Expiration Date _____

2. SCHOOL OF NURSE-MIDWIFERY & LOCATION (city and state)

3. DATE OF COMPLETION

4. ARE YOU CERTIFIED BY THE AMERICAN COLLEGE OF NURSE-MIDWIVES (ACNM)?
YES ☐ NO ☐
If yes: Certificate Number _____ Date of Issuance _____
If no: Date of National Certification (ACNM) Exam _____

5. HAS YOUR ACNM CERTIFICATION EVER BEEN REVOKED OR SUSPENDED?
YES ☐ NO ☐ If yes, explain - include date, type of action (on separate sheet)

APPLICATION FEES: Please check applicable blank: (Make check payable to Department of Regulation and Licensing and attach to application).

_____ $ 53.00 Initial Credential Fee

_____ **TEMPORARY PERMIT**
$ 10.00 Is required in addition to the above fee (*non-refundable*)

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

6. ARE YOU CERTIFIED AS A NURSE-MIDWIFE IN ANY OTHER STATE(S)?
   YES ☐ NO ☐ If yes, list:

7. HAS ANY STATE BOARD OF NURSING EVER TAKEN DISCIPLINARY ACTION AGAINST YOUR LICENSE OR CERTIFICATE AS A REGISTERED NURSE OR AS A NURSE-MIDWIFE?
   YES ☐ NO ☐ If yes, explain - include state, date, type of action (on separate sheet)

8. IS DISCIPLINARY ACTION PENDING AGAINST YOU IN ANY STATE?
   YES ☐ NO ☐ If yes, explain - include state, date, type of action (on separate sheet)

If, after a certificate has been issued on this application, it is ascertained that misrepresentation of facts, or fraudulent statements have been made, the certificate so issued may be revoked by the Board of Nursing and the applicant becomes subject to legal prosecution.

I state, under the penalties for false swearing provided for in Section 946.32, Stats., that I am the person who is referred to on this application, that the statements and representations made hereon are in my handwriting and are strictly true in every respect.

_____ _____
Signature of Applicant Date

_____
Telephone Number (voluntary)

Subscribed and sworn to before me this _____ ____day of

_____ , 20_____

_____
Notary Public SEAL

My Commission:_____

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name Middle Initial Last Name

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.